STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXX
Petitioner **File No. 86556-001**
v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
This 8th day of February 2008
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On December 3, 2007, XXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on December 10, 2007.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Office of Financial and Insurance Services received BCBSM's response on December 18, 2007.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM Community Blue Group Benefits Certificate (the certificate). Rider CBD $1000-NP (Community Blue Deductible Requirement For Nonpanel Services) and Rider CBC 40% NP (Community Blue Copayment Requirement 40% For Nonpanel Services) also apply. The

Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On April 18, 2007, the Petitioner underwent a lumbar laminotomy at XXXX, an ambulatory surgery facility, in XXXX. XXXX does not participate with BCBSM or Blue Cross and Blue Shield of XXXX and neither do the two doctors that provided this surgery. BCBSM denied coverage for the $20,000.00 facility charge and paid only $588.00 toward the $29,000.00 charged by the surgeons.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on October 3, 2007, and issued a final adverse determination dated October 19, 2007.

III
ISSUE

Is BCBSM required to pay an additional amount for the surgical services provided to the Petitioner on April 18, 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner has suffered from back pain for some time. He had tried a number of different types of treatments with no relief. It was finally recommended to him that he needed to see a neurosurgeon.

The Petitioner did a lot of research on spinal stenosis surgery and found that it was fairly invasive, requires a hospital stay, and rehabilitation can take a long time. He happened across XXXX during one of his online searches. The description of the use of laser instead of a traditional scalpel was appealing to him.

The Petitioner says XXXX told him they did not participate with BCBS and that he should make certain that the laminotomy was covered. He says he called BCBSM and they explained the out-of-network deductible and copayment would apply but the surgery would be covered.

After the Petitioner had his back surgery at XXXX, BCBSM only paid $558.90 of the more than $49,000 charged for the care. Had he known that BCBSM would not pay for his care, he says he would have had traditional surgery by an in-network doctor.

The Petitioner believes that under the circumstances BCBSM should pay significantly more for his surgery.

BCBSM's Argument

BCBSM says it correctly paid for the services the Petitioner received from a nonpanel provider.

Section 3 of the certificate, *Coverage for Hospital, Facility and Alternatives to Hospital Care,* says: "We pay for medically necessary facility services provided by a BCBSM **participating** ambulatory surgery facility." Since XXXX does not participate with BCBSM or the XXXX Blue Cross and Blue Shield plan, BCBSM is not required to pay for any of the $20,000.00 facility charge

Section 4 of the certificate, *Coverage for Physician and Other Professional Services,* explains how BCBSM pays nonpanel and nonparticipating providers.[1] It says that BCBSM pays its "approved amount" for physician and other professional services -- the certificate does not guarantee that charges will be paid in full. In addition, since the surgeons in this case do not participate with BCBSM, they are not required to accept BCBSM's approved amount as payment in full.

The amounts charged by surgeons and the amounts paid by BCBSM for the April 18, 2007, surgery are set forth in this table:

[1] As nonparticipating providers, the surgeons are by definition also nonpanel providers.

Procedure Code	Amount Charged	BCBSM's Approved Amount	Amount Paid by BCBSM	Out of Network Sanctions[2]
63042	$ 23,500.00	$ 1,357.02	$ 558.90	$ 798.12
00630	$ 2,000.00	$ 295.74	$ 0.00	$ 295.74
86891	$1,597.00	$ 110.81	$ 0.00	$ 110.81
27096	$ 2,000.00	$ 104.05	$0.00	$ 104.05
77003	$ 650.00	$ 650.00	$0.00[3]	$0.00
Totals	$ 29,747.00	$ 2,517.62	$ 558.90	

BCBSM applied nonpanel sanctions (i.e., deductible and copayment) to its approved amounts before it made its payment.

The maximum payment level for each service is determined by a resource based relative value scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service, is regularly reviewed to address the effects of changing technology, training, and medical practice, and is adjusted by geographic region. The service was performed in Florida and the claim was submitted through the Florida Blue Cross and Blue Shield plan so in this case BCBSM used the XXXX plan's maximum payment level as its approved amount.

BCBSM contends that it has paid the proper amount for the Petitioner's care by a nonpanel provider and is not required to pay more.

Commissioner's Review

The certificate describes how benefits are paid and it clearly says that BCBSM pays the facility fee for an ambulatory surgical facility only if it participates. The record establishes that XXXX does not participate with either BCBSM or the XXXX BCBS plan. Therefore, the $20,000 facility fee that XXXX charged for the Petitioner's surgery is not a covered benefit and BCBSM is not required to pay for it.

[2] Amounts applied to the Petitioner's $1,000.00 nonpanel deductible and his 40% nonpanel copayment.

The certificate also explains that BCBSM pays an "approved amount" for physician and other professional services. The approved amount is defined in the certificate as the "lower of the billed charge or [BCBSM's] maximum payment level for a covered service." Participating and panel providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full and may bill for the balance of the charges.

The certificate explains this (on pages 4.26 – 4.27):

> When you receive covered services from a nonpanel provider, you will be required to pay a nonpanel deductible and a copayment for most covered services….
>
> * * *
>
> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial….
>
> **NOTE**: Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

BCBSM paid the XXXX BCBS plan's maximum payment level for the Petitioner's surgical care, minus the deductible and the copayment required by Rider CBC $1000-NP and Rider CBC 40% NP when a nonpanel provider is used. Nothing in the record establishes that the Petitioner met any of the exceptions that would waive the nonpanel sanctions, e.g., when the service is the initial exam to treat a medical or accidental injury, or when the Petitioner is referred to a nonpanel provider by a panel provider.

It is unfortunate that the Petitioner was not able to use a participating provider. Nevertheless, there is nothing in the terms and conditions of the Petitioner's certificate that requires BCBSM to pay more than its approved amount (minus the nonpanel sanctions) to a nonparticipating provider, even if no participating provider was immediately available or even if the Petitioner was not aware that a provider did not participate.

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[3] BCBSM did not pay for PC 77003 since this service is included in the payment of a related service, PC 63042.

Finally, the Petitioner believes that BCBSM informed him in telephone conversations that it would cover all the charges for his surgery at XXXX. BCBSM denies that it misinformed the Petitioner, saying that he was told about the surgery benefits from both in- and out-of-network providers. Under PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms and conditions of the applicable insurance contract and state law. Resolution of the factual dispute described by Petitioner cannot be part of a PRIRA decision because the PRIRA process lacks the hearing process necessary to make findings of fact based on evidence such as oral statements.

The Commissioner finds that BCBSM has paid the Petitioner's claims correctly according to the terms of the certificate and is not required to pay more for the Petitioner's care.

V
ORDER

BCBSM's final adverse determination of July 13, 2007, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's care provided at XXXX.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.